MARYLAND
Department of Health

Client Services
500 N. Calvert St., 5th Fl., Baltimore, MD 21202
Phone: (410) 767-6535 or Toll Free: 1-800-205-6308
or TTY- Maryland Relay Service 1-800-735-2258
Fax Numbers: (410) 333-2608; (410) 244-8696; (410) 244-8617

A-2: No Income and/or Homeless Verification Form

Required Proof of no Income/Maryland Residency/Homelessness

MADAP ID: 94 _____

Instructions: Complete section 1 or 2.

First Name: _____ MI: ___ Last Name: _____ Suffix: ___ Date of Birth: __/__/__

Section 1. Supporting relative or friend (all information is required)

I, _____, certify that _____ is:
(applicant)

☐ **Currently without income.**
I am supporting him/her by providing the following:

☐ Payment for room and board outside of my home.
☐ Free room and board in my home.
☐ Other, please explain: _____

☐ **I certify that the information provided on this form and any attached documentation is true, correct and complete.**

First Name: _____ Last Name: _____ Relationship to Applicant: _____

Street Address: _____ City: _____ State: ___ Zip code: _____

Phone number: _____

Signature: _____ Date: _____

Section 2. Shelter or Agency *(if applicant is homeless)*

I, _____, certify that _____resides at _____, at
(Name of Shelter Representative) (Applicant) (Facility Name)
_____ for the period of: ☐ less than 6 months ☐ 6 to 12 months ☐ 12 months or more.
(Facility Location)

☐ **The applicant has no income.**
☐ **The applicant has income.**

☐ **I certify that this information is true, correct and complete.**

Organization Name: _____

First Name: _____ Last Name: _____

Street Address: _____ City: _____ State: ___ Zip code: _____

Phone number: _____

Signature: _____ Date: _____